

Care Quality Commission

Inspection Evidence Table

Elmdene Surgery (1-540476120)

Inspection date: 27 November 2018

Date of data download: 26 November 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe

Safety systems and processes

Safeguarding	Y/N
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients.	Yes
Disclosure and Barring Service checks were undertaken where required	Yes
Explanation of any answers:	
<p>Policies were available to all staff on the shared drive. Staff were required to read and sign to show they had done so.</p> <p>The practice had a system to identify vulnerable patients. They had identified vulnerable patients registered at the practice and added a yellow flag to the patient journal. This could be seen by reception staff and GPs.</p> <p>We found that staff who acted as chaperones were trained for their role and had received a DBS check. There was system to ensure DBS checks were carried out prior to staff starting work at the practice.</p>	

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Yes
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Staff who require medical indemnity insurance had it in place	Yes
Explanation of any answers:	
Three staff files were reviewed and these contained all the required information.	

Safety Records	Y/N
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Yes
Fire risk assessment: Date of completion:	Yes 02/10/18
Actions were identified and completed. There was a specific fire risk assessment for each site and recommendations were met according to a time-based action plan.	
Health and safety	
Health and safety risk assessment and actions: Date of last assessment:	Yes 20/09/18
<p>Additional comments:</p> <p>A health and safety risk assessment had been carried out by an external agency. Risks identified had been actioned. For example, lone working was highlighted as an area of risk, and as a result, the practice ensured that two members of staff worked together; the COSHH materials had been moved to a steel cupboard.</p>	

Infection control	Y/N
Risk assessment and policy in place Date of last infection control audit: The practice acted on any issues identified.	Yes August 2018
<p>Detail:</p> <p>Actions were identified and completed, for example, a corroded cupboard had been replaced.</p>	
<p>Explanation of any answers:</p> <ul style="list-style-type: none"> The practice effectively managed infection control risks. There was an infection control policy. There was a risk assessment. An audit had been carried out at all three sites and this listed actions to be taken or their date of completion. Some infection control risks were noted during the previous inspection. For example, there was a patch of corrosion on the surface of the nurse work station in one treatment room at Elmdene Surgery, this work station had been replaced; a hole in the wall in the treatment room next to the sink at Elmdene Surgery had been repaired; the patients' toilet seat had been replaced at The Bean Surgery; the open bins in the treatment room and toilet at Elmdene Surgery had been replaced. The infection control audit was scheduled to be completed on a six-monthly basis and reviewed with the practice manager and lead GP. 	

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans were developed in line with national guidance.	Yes
Staff knew how to respond to emergency situations.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
In addition, there was a process in the practice for urgent clinician review of such patients.	Yes
The practice had equipment available to enable assessment of patients with presumed sepsis.	Yes
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes
Explanation of any answers:	
<ul style="list-style-type: none"> • Staff members had buddies and specific roles. For example, one member of staff was a designated care navigator; a prescription clerk; a member of staff responsible for scanning, one for the workflow. Staff were able to work across the three sites. • The practice had recruited an experienced Practice Manager. They had also recruited additional staff and created new roles. A clinical pharmacist had been recruited to work with the dispensary team. Two experienced and skilled dispensers had been recruited to work full time. • There was a clear organisation chart to show each member of the team and their role within the practice. 	

Appropriate and safe use of medicines

Medicines Management	Y/N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Yes
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	Yes

Up to date local prescribing guidelines were in use.	Yes
Clinical staff were able to access a local microbiologist for advice.	Yes
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	Yes
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Yes
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes Monthly
There was medical oxygen on site.	Yes
The practice had a defibrillator.	Yes
Both were checked regularly and this was recorded. weekly	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Yes

Explanation of any answers:

- There was a system to help ensure the safe management of prescription paper at Elmdene Surgery, The Bean Surgery and Bennett Way Surgery, in accordance with national guidance on the security of prescription forms. At all sites there was a log of prescription form numbers in use and staff could demonstrate where the controlled stationary was kept out of hours for safe keeping.
- There was a process for the management of high risk medicines and this was being embedded at the practice. The practice had 28 patients prescribed the medicine Methotrexate. The practice had carried out an audit which showed 25 were up to date with their reviews. Two patients had not had a blood test for over a year. A third patient had a blood test carried out in August 2018 and was booked in for their next test on November 2018. Patients who were not engaging in the review process had been contacted three or four times by letter but were still receiving their medicine. The practice introduced an additional section to their medicines management policy to stop repeat prescribing (where safe to do so) where patients did not comply with having appropriate monitoring.
- We looked at the management of patients receiving Lithium. The records of four patients who were prescribed Lithium had been checked and reviewed. We looked at the management of four patients prescribed Warfarin and saw that all bloods tests had been completed and reviewed prior to re-prescribing.
- There were two patients who had their bloods taken by London hospitals and the practice were implementing a plan to help ensure that these results were seen prior to re-prescribing medicine.
- The practice had systems to help ensure the safe and secure management of high risk medicines and controlled drugs were stored and recorded correctly.
- We found the practice maintained an accurate record of the destruction of controlled drugs. These were now destroyed with the support of the Dartford Gravesham and Swanley medicines optimisation team. The practice employed pharmacist audited the controlled drug register monthly.
- New oxygen cylinders had been received at each site and these were stored in accordance with best practice. They were wall mounted and secured. These were checked weekly and this

was documented.

- There was a systematic approach to the provision of emergency equipment. Elmdene Surgery had an external defibrillator (AED) at the last inspection, and the practice had purchased additional AED's for both The Bean Surgery and Bennett Way Surgery. This could help to mitigate the risk to a patient receiving timely life critical access to emergency provision.
- Vaccine and medicine fridge temperatures were checked for the last three months. These were within range to help keep medicines safe. The practice had introduced a system to double check the temperatures using a data log and a manual recorded check. The cold chain procedure and what to do in the event of a breach was displayed on the front of the fridge.

Dispensing practices only	Y/N
There was a GP responsible for providing effective leadership for the dispensary.	Yes
Access to the dispensary was restricted to authorised staff only.	Yes
The practice had clear Standard Operating Procedures for their dispensary staff to follow.	Yes
The practice had a clear system of monitoring compliance with Standard Operating Procedures.	Yes
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
If the dispensary provided medicines in weekly or monthly blister packs (Monitored Dosage Systems) there were systems to ensure appropriate and correct information on medicines were supplied with the pack.	Yes
Staff were aware of medicines that were not suitable for inclusion in such packs and had access to appropriate resources to identify these medicines. Where such medicines had been identified staff provided alternative options that kept patients safe.	Yes
The home delivery service, or remote collection points, had been risk assessed (including for safety, security, confidentiality and traceability).	Yes
Information was provided to patients in accessible formats e.g. large print labels, braille labels, information in variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described process for referral to clinicians.	Yes
Any other comments on dispensary services:	
<ul style="list-style-type: none"> • Bennett Way Surgery and The Bean Surgery both had dispensaries. The arrangements for dispensing medicines helped to keep patients safe and there were governance systems established and oversight of all three practices. There was a named GP to provide leadership for the dispensaries. An experienced practice manager had been recruited to embed a single governance system across all three sites and a clinical pharmacist employed to oversee the dispensaries and their staff team. Two experienced and skilled dispensing staff had been employed on a full-time basis. • The practice was able to provide evidence of standard operating procedures (SOP) at both dispensaries and staff spoken with knew what these contained. Staff members also reported that there were clear processes and on-call support from the practice employed pharmacist. 	

- Medicines dispensed at The Bean Surgery were routinely second checked by either a second dispenser or the practice employed pharmacist.
- The practice had a system to monitor medicines that were not collected by the patient. The dispensaries had a log of medicines not picked up. Staff told us that this information was added to the patient's record so the GP could review at the next prescription request.
- The practice had a system to help ensure that only suitable medicines were included in dosette boxes. The practice employed pharmacist oversaw requests for medicines to be added to a dosette box and assessed the risk.
- The practice had a system for monitoring medicine errors and to carry out audits to improve quality. The dispensaries had a near miss log in place. The practice employed pharmacist reviewed any near miss incidents with the GP and Practice Manager at monthly meetings. Medicines errors were reported via a significant incident form. The lead GP confirmed this process will be strengthened by cross referencing this into the medicines SOP folder and the practice employed pharmacist will be carrying out six monthly overarching audits to facilitate high level medicines management feedback to the lead GP.
- There was a protocol for the practice to deliver medicines to a patient's home. The practice employed pharmacist had written a series of SOPs including regarding the delivery of medicines to a patients' home. These were signed by all staff working to them. At the Bean surgery there was a log of deliveries signed by the few patients receiving them. There were no deliveries to patients from Bennett way.

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Yes
Staff understood how to report incidents both internally and externally	Yes
There was evidence of learning and dissemination of information	Yes
Number of events recorded in last 12 months.	8 Since July 2018
Number of events that required action	8

Example(s) of significant events recorded and actions by the practice;

Event	Specific action taken
There was a delay in a two week wait referral as it was rejected by the hospital as not submitted on e-referral.	A further referral was made as soon as the practice were aware of the rejection using the correct procedure. An extensive locum pack was organised explaining the process for referral and training was arranged.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Yes
Staff understand how to deal with alerts	Yes

Comments on systems in place:

- The lead GP partner was the GP lead for safety alerts and these were discussed at a monthly meeting which was attended by staff from all three sites. The minutes were distributed and signed as read by people unable to attend the meeting. Minutes of meetings were reviewed which confirmed this.

Any additional evidence

The practice recorded and investigated significant events appropriately. A new system had been implemented across all three practices. Significant events and complaints were a standard item on the monthly practice meeting agenda, and minutes seen confirmed this. Documents reviewed demonstrated that the practice shared events with the staff team, took appropriate and timely action and used the outcome for learning. The near miss recording format at the dispensaries were different. However, the practice put an action in place to resolve this during the inspection. Events were analysed for trends and although none were apparent, the practice manager did identify that there were some concerns regarding prescriptions and as a result recruited a prescription clerk.

Effective

Effective needs assessment, care and treatment

Any additional evidence or comments

The practice has been improving the way that patients are read coded. Searches have been carried out to help identify patients with long term conditions and on disease registers such as asthma, atrial fibrillation and cancer. Since the last inspection an additional forty patients with asthma have been identified. We reviewed four patients with atrial fibrillation and these were all correctly coded. We reviewed patients who were prescribed the high-risk medicine Methotrexate, and these were correctly coded. We reviewed three patients who had been diagnosed with cancer and saw that they were all correctly coded and that two of the patients had received a first review within the specified timeframe, and that the third is still within the timeframe for review. The practice were working to ensure all patients were coded correctly and had carried out a large amount of this process since the last inspection. A system for ensuring correct coding is being progressed.

Well-led

Leadership capacity and capability

Examples of how leadership, capacity and capability were demonstrated by the practice
<p>The practice had recruited an experienced practice manager in August 2018. Previously, the lead GP had been managing all three practices alongside carrying out a full quota of clinical sessions. The practice had devised and implemented governance structures across all three surgeries. Two salaried female GPs had started work at the practice on 1st August 2018</p> <p>A sustained and consistent approach to leading the practice was in process and this helped to ensure that leaders had both the capacity and capability to provide safe care and treatment.</p> <p>Leaders were aware of the challenges to the practice and had taken steps to address these. They had worked hard to make the improvements detailed in the previous inspection and this was reflected in our findings.</p>

Culture

Examples that demonstrate that the practice has a culture of high-quality sustainable care
<p>We found that the practice had employed 14 new members of staff since the last inspection. Six of these were additional roles, which included an experienced practice manager and a clinical pharmacist. Staff spoken with told us that they felt supported in their roles and clear about the policies and procedures they were required to follow. There was a clear system for reporting incidents and near misses and these were shared with the practice team for the purposes of learning and improvement.</p> <p>The Dispensary team told us they felt supported by the practice and that there were clear procedures and processes to follow regarding near misses and significant events.</p>

Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies	The policies were stored on the shared drive and were standardised across the three sites. The policies had the date they were established and the name of an accountable person who had completed this task.
Other examples	There were regular monthly staff meetings and these were clearly minuted with actions to be taken in a specific timeframe. There was evidence of clinical meetings and dispensary meetings. Multi-disciplinary meetings had been organised by the Clinical Commissioning Group and were held in groups of practices in the locality. All staff, both clinical and non-clinical had lead areas.
Y/N	
Staff were able to describe the governance arrangements	Yes
Staff were clear on their roles and responsibilities	Yes

Managing risks, issues and performance

Examples of actions taken to address risks identified within the practice

Risk	Example of risk management activities
Health and safety risk assessment.	Health and safety and environmental risk assessments were carried out across all sites. An external organisation carried out a risk assessment at Elmdene Surgery in September 2018. Two recommendations were made, with regards to a lone working assessment and an update to the health and safety statement. Both actions had been completed and appropriate action taken.
Fire risk assessment.	A fire risk assessment had been conducted at each practice by an external organisation. Three recommendations were made and these had been completed or had a completion date in December 2018.
Infection prevention and control risk assessment	An audit had been conducted in August 2018 and actions identified had been addressed.
Medicines management and emergency risks.	There were risk assessments for emergency medicines that were not kept at the practice and a process for managing high risk medicines had been implemented and was being progressed.
Significant events and complaints.	There was a single system for incidents and complaints across the three practices.

Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

Audit area	Improvement
Diagnosis and management of stable COPD in a general practice setting.	To assess and diagnose patients registered with COPD, in accordance with NICE guidelines, to improve patient quality of life.
Diabetes.	To check NICE guidelines are complied with in the management of diabetes within the practice.
Joint injections.	To review the number of joint injections carried out at the practice and where this has saved a referral to secondary care.

Any additional evidence

The practice had three examples of relevant clinical audits carried out since the previous inspection. These were first cycle, but demonstrated that a system had been developed and was in progress.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as comparable, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as comparable to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	Comparable to other practices	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.

- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.([See NHS Choices for more details](#)).